Task Force on Health Care Access and Reimbursement
July 11, 2008
Minutes

Task Force members present: Secretary John Colmers (chair), Senator Robert Garagiola, Beth Sammis (for Ralph Tyler), Dr. Joseph Fastow, David Wolf, Stuart Guterman, Dr. Ivan Walks, Mary Lehman (for Delegate Pena-Melnyk), Ellen Kuhn (for JB Howard), Dr. George Bone. Absent: Senator Thomas Middleton, Delegate Robert Costa, Dr. Fannie Gaston-Johansson, T. Eloise Foster.

Staff present: Rex Cowdry, Ben Steffen, Linda Bartnyska, Lydia Isaac

1. Secretary Colmers called the meeting to order at 1:13 pm. At 2:50 pm, when a quorum was present, the minutes were approved as written.

2. Ben Steffen provided a brief overview of the meeting and a summary of the discussions of the subgroup on hospital reimbursement. At the subgroup meetings, discussions focused on adjusting the non-par formula, alternative physician based payment systems, and the potential for forming a pilot project to test alternative ways of paying physicians. An uncompensated care fund for emergency room doctors was also discussed, but given the economic climate, the size of the fund needed, and the likelihood that uncompensated care will be less of a problem because of the expansion of Medicaid that went into effect July 1st; the feasibility of implementing this alternative seems unlikely.

3. Practice Formation: What We Can Learn From National Studies, Dr. Hoangmai H. Pham

Information was shown on the national distribution of physician practice size and type. Using information from the Community Tracking Study, characteristics of physician practice consolidation were investigated. Highly consolidated markets like Cleveland tended to have dominant hospital systems, increasing hospital employment of some specialists and having few independent practices. Moderately consolidated markets had strong physician hospital organizations and balanced/competitive hospital markets. Communities with more diffuse physician markets had several moderately sized multi-specialty groups.

Single specialty groups tend to not thrive in highly consolidated markets. There are several factors that facilitate the formation of large multi-specialty groups, including capitation and consolidated health plan and hospital markets, as well as collaborative cultures and payer expectation for efficiency. The factors that influence the formation of large single-specialty groups include loose provider networks and permissive certificate of need laws for hospitals.

Quality of care for patients in large multi-specialty groups tends to be better and physicians are more likely to have access to information technology and perform higher

on standardized metrics. These practices are better able to market to specific patient subgroups and negotiate more favorable rates. The ability of these groups to negotiate is highly dependent on the level of health plan consolidation. The larger groups are able to take advantage of performance incentive and more able to invest in ancillaries and facilities. Large practice size modestly reduces fragmentation. From a physician perspective consolidation has many benefits including lifestyle benefits and management autonomy. For policy makers multi-specialty groups probably offer better care coordination, but not all physician services need to be consolidated and but all markets are open to consolidation. Ophthalmology is one example of a specialty that experience little benefit from multi-specialty practice formation. Encouraging consolidation involves increasing the business case for multi-specialty group and integration of health systems.

The discussion of this presentation centered on the role that consolidation plays in quality of care. Several members pointed out that the increases in quality come from changes in the system and not the physician, in that the solo physician is not doing quality improvement. Using payment to increase quality and efficiency would encourage consolidation and if payment systems pay for needed services instead of the paying the system then would improve quality of care. Others caution that practice consolidation alone will not increase efficiency or decrease unneeded utilizations, need reimbursements that pay accurately or will practice will make up for losses on procedures in order to increase revenue.

Also discussed were the issues of safety net providers and the role of health disparities due to geography, racial/ethnic populations and payer mix. In order to pay physicians for performance need to understand the interplay of many complex factors and not penalize safety net providers because their patient population is sicker, less compliant. Several members pointed out what is being done in the British system to compensate for different patient populations. The National Health Service made a large investment in figuring out how to reimburse solo practice for pay for performance but the culture of reimbursement is different and the government takes a larger role.

3. Desirability of Expanding Regulatory Activities.

Does the Maryland Insurance Administration have the authority to regulate rate setting and market-related practices of health insurance? Presenter Beth Sammis

Under competition the current statutes governing the negotiation of reimbursement rates between providers and carriers were summarized. §§ 15-113 of the insurance articles provides the “rules of the road” in which providers cannot be reimburse lower than the negotiated rate and that bonuses and incentives may be provided given they follow certain parameters. These parameters are broad and there does not seem to be a bonus system that is not permissible under the law. An alternative to competition is regulation in which there are 3 options, all-payer system, State sets provider reimbursement or “safe Harbor”, where physicians compete as a group. Some of these methods have already been proposed recently and rejected.

For competition statutory changes could include modifying §§19-710.1 to include greater transparency by using a percentage of Medicare and/or posting the fee schedule on the internet and more accountability by requiring the filing of attestation fee schedules complies with current provisions. Under regulation statutory change could include modifying bonus provision of §§ 15-113 of the Insurance Article to specify permissible payment methodologies for bonuses for certain designated purposes and require filing proposed bonus payment methodologies for "prominent carriers" OR modify §§ 15-113 of the Insurance Article to allow carriers to pay a certain percentage less that the negotiated amount for specific practices and require filing proposes "reduction" payment methodologies for "prominent carriers". Other alternatives include modifying anti-trust statutes for a "safe-harbor" and modifying insurance articles to require carriers to pay in accordance with a state payment system and pay hospital based physicians through the all payers system. There are pros and cons to each scenario but whether one chooses competition or regulation finding consensus is difficult to achieve. To answer the question: does the MIA have the regulatory tools depends on what matters and what you want done to achieve.

The discussion centered on the notion transparency. How do we make the information available and public? Medicare publishes physician rates, it is possible to compare those rates to private payer fees paid to non-par physicians. The state could require that the private payers use the Medicare fee schedule as the comparison benchmark. There was some debate over the ability to compare rates among other physician. Several physicians likened the market to the "wild west" in which anything goes. There are physicians that are being out gunned even while the state lacks the proper tools to regulate the wild west. The tools include enforcing that physicians are paid the minimal standard fees for non-par services. MIA has no way of knowing for sure unless an individual physician brings a complaint to them. Carriers have to provide physician with the 50 most commonly billed codes. One difficulty with transparency and posting a fee schedule is that that the state falls in 3 different Medicare fee schedules. If violation found a fine of $125,000 is levied. Some members expressed concerns about the fine not being enough.

The issue of bonus system payments was also discussed. Currently the payers can do what they want to do for bonus. The MIA has not seen a bonus system that is not permissible. On the legislative option would be to modify or strengthen language about specific bonuses. Several members commented on the issue of making sure that any mandates would be implemented across the board and making access to capital accessible to all types of provider. The Task Force discussed how to reward primary care physicians for reducing available emergency and inpatient admissions..

Physician Credentialing: Universal Credentialing Data Source, Lydia Isaac A brief overview of the Council for Affordable and Quality Health Care's (CAQH) Universal Credentialing Datasource (UCD) which is a uniform, electronic data collection system that aims to eliminate redundancy and inefficiency associated with traditional paper based credentialing processes. UCD is available to providers free of charge in all 50 states and the District of Columbia. Several states have adopted it as their means of doing

provider credentialing. The system allows physicians to enter their credentialing information electronic and then authorize the data to health plans, hospitals and other healthcare organizations. CAHQ will send emails quarterly to remind physicians that it is time to update their system. UCD is endorsed by NCQA, URAC , JACHO and many major health plans.

The discussion centered on the ability of UCD to actually do the credentialing. The Maryland Insurance Administration did a study of UCD and recommended the creation of a state law that creates and accepts credentialing from a delegate. They MIA recommended the changes in the Board of physicians credentialing form to mimic the UCD form in order to facilitate the use of the system. Suggestions were made to have the state take on the task of primary source verification and Maryland would be an innovator and the first to have a single repository system.

5. Plans for new studies required under senate bill 744, Janet Sutton, PhD

A plan for investigating the issued outlined under SB 744. These include the desirability of providing incentives for after hours care. The research questions include: definition of after hours care; how much can be provided; is patient demand for care being met; how would reimbursement be structured and what are carrier policies/views; what impact will it have on cost savings. The analytical approach includes an environmental scan and interviews with stakeholder.

The 2nd issue involves the desirability of primary care physicians providing mental health services. The research questions include: the clinical appropriateness; legal/regulatory restrictions; billing codes and carrier policies; access; experience from other state and impact on health care costs.

Several members of the task force offered additional suggestions such as looking at phone call to the minute and the difference in small and large practices. Concerns from payers about phone calls and emails. Look at the payment demand for after hours because the need is met in retail clinics and ER. There are liability issues and ancillary costs. Looking how physicians organize themselves and the ramifications of this for after-hours care.

6. Plans for September meeting

This is when the task force makes recommendations on what to tell General Assembly. The will be the principles on which we would make recommendations. There ought to be cost savings to system, increases in access and affordability. Changes should not lead to higher costs to patients especially when they have no ability to choose. Circulate ideas on guiding principles in order to reach consensus on. A suggestion was made to offer the opportunity for public comment.

The meeting was adjourned at 3:48pm.